NOTICE OF PROPOSED RULE ADOPTION

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

Miss. Division of Medicaid
c/o Ginnie McCardle, Staff Officer
Walter Sillers Building
550 High St.
Suite 1000
Jackson, MS 39201-1399
(601) 359-6310
http://www.dom.state.ms.us

Specific Legal Authority authorizing the promulgation of Rule: Miss. Code Ann. §43-13-121(1972), as amended

Reference to Rules repealed, amended or suspended by the Proposed Rule :
Provider Policy Manual Section 64.08

Explanation of the Purpose of the Proposed Rule and the reason(s) for proposing the rule:
AP2008-57 This administrative policy amendment is being filed to update the Division of Medicaid's policy regarding Long-Term Care/Pre-Admission Screening (PAS). Some updates have been made to the actual screening tool.

This rule is proposed as a ☒ Final Rule, and/or a ☐ Temporary Rule (Check one or both boxers as applicable.)

Persons may present their views on the proposed rule by addressing written comments to the agency at the above address. Persons making comments should include their name and address, as well as other contact information, and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

Oral Proceeding: Check one box below:

☐ An oral proceeding is scheduled on this rule on Date: Time:
Place:

If you wish to be heard and present evidence at the oral proceeding you must make a written request to the agency at the above address at least 5 day(s) prior to the proceeding to be placed on the agenda. The request should include your name, address, telephone number as well as other contact information; and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

☒ An oral proceeding is not scheduled on this rule. Where an oral proceeding is not scheduled, an oral proceeding will be held if a written request for an oral proceeding is submitted by a political subdivision, an agency or ten (10) persons. The written request should be submitted to the agency contact person at the above address within twenty (20) days after the filing of this notice of proposed rule adoption and should include the name, address and telephone number of the person(s) making the request; and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

Economic Impact Statement: Check one box below:

☒ The agency has determined that an economic impact statement is not required for this rule, or

☐ The concise summary of the economic impact statement required is attached.

The entire text of the Proposed Rule including the text of any rule being amended or changed is attached.

Date Rule Proposed: December 5, 2008

Proposed Effective Date of Rule: January 1, 2009

Executive Director
Signature and Title of Person Submitting Rule for Filing

The PAS consists of ten (10) domains, or sections, most of which have two (2) or more subsections. The table below lists the sections/subsections and identifies the populations for whom each subsection applies.

Section/Subsection		Applies to:
I	**Intake**	All applicants
II	**Functional Screen**	
IIA	ADL's & IADL's	All applicants
IIB	Communication/Sensory	All applicants
III	**Cognitive Screen**	All applicants (caregiver response component applies only if caregiver is present)
IV	**Mood/Psychosocial & Behaviors**	
IVA	Mood/Psychosocial	All applicants
IVB	Behaviors	All applicants
V	**Medical Screen**	
VA	Medical Conditions	All applicants
VB	Health-Related Services	All applicants
VC	Medications	All applicants
VD	Medical Stability	All applicants
VE	Medical Summary	All applicants
VI	**Social Supports**	
VI.1	Primary Caregiver	All applicants ~~with a primary caregiver~~ except Nursing Home and other institutional residents not seeking community placement.
VI.2	Formal Agency Supports	All applicants
VII	**Home Environment**	All applicants except Nursing Home and other institutional residents not seeking community placement

VIII	**Informed Choice**	
VIII.1	Individual Strengths	All applicants except Nursing Home and other institutional residents not seeking community placement
VIII.2	Program Options & Desired Assistance	All applicants
VIII.3	Individual Choice	All applicants
IX	**Level II Determination (PASRR)**	All applicants presented with Nursing Facility placement as an option in Section VIII
X	**PAS Summary & Physician Certification**	All applicants

The Pre-Admission Screening (PAS) Application for Long Term Care may be reviewed in its entirety on the following pages of this section.

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

I. INTAKE

*Screener(s)

*Screener 1 Name (Last, First) & Credential:	Screener 2 Name (Last, First) & Credential:	
Screener 3 Name (Last, First) & Credential:	Screener 4 Name (Last, First) & Credential:	
*Organization:		
*Mailing Address:		
*City:	*State:	*Zip Code:
*Telephone:	*Fax:	Email:
Provider Number (if applicable):		
*Location at time of screen (check box): ❑ Person's Residence ❑ Nursing Facility ❑ Hospital ❑ Other (specify): _____		

*Person

*Name ~~(Last, First, Middle):~~ *First, Middle Initial, *Last):		
*Street Address:		
*City:	*County:	*State:
*Zip Code	Telephone:	
Medicaid Number:	~~Medicare Number:~~ *SSN:	
~~SSN:~~ Medicare Number:	*DOB ~~(MM/DD/YR)~~ (MM/DD/CCYY)	*Gender (check box) ❑ Male ❑ Female

*Designated Representative

If none, enter "none" on Name line

*Name ~~(Last, First, Middle):~~ (*First, Middle Initial, *Last)		
*Street Address:		
*City:	*State:	*Zip Code:
*Relationship to Person:	Telephone:	
Comments:		

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

I. INTAKE - *continued*

***Other Contacts**

*Physician:	*Telephone:
*Physician Mailing Address, City, State, Zip:	
Case Manager (if different from screener):	Telephone:
Case Manager Mailing Address, City, State, Zip: (if different from screener):	

***Usual Living Arrangement**

❑ Lives Alone	❑ Nursing Facility	Other:
❑ Lives with Spouse	❑ Assisted Living Facility	
❑ Lives with other Relative	❑ ICF/MR	
❑ Lives with non-Relative	❑ Other (specify)	
Facility Name (if applicable):		

***Application Type**

- ❑ New Long Term Care Applicant
- ~~❑ Recertification – Institutional Resident (no requested change in living arrangement)~~
- ~~❑ Recertification – Institutional Resident (request for return to community)~~
- ❑ Recertification – Elderly & Disabled Waiver
- ❑ Recertification – Assisted Living Waiver
- ❑ Recertification – Traumatic Brain Injury/Spinal Cord Injury Waiver
- ❑ Recertification – Independent Living Waiver

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

II. FUNCTIONAL SCREEN

A. ACTIVITIES OF DAILY LIVING (ADLs) & INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used

ADL SCALE	
0 =	**Independent** - Person is independent in completing activity safely
1 =	**Supervision** - Person can complete activity safely with cueing, set-up or standby assistance OR limited/occasional physical/hands-on assistance
2 =	**Physical Assistance** - Person can participate in activity but requires physical/hands-on assistance to complete safely
3 =	**Total Dependence** - Person is completely dependent on others to complete activity safely

Activity	Score
*1. **MOBILITY/AMBULATION** – How well is the person able to purposefully move within his or her residence/living environment?	
*2. **COMMUNITY MOBILITY** – How well is the person able to move around the neighborhood or community, including accessing buildings, stores and restaurants, and using any mode of transportation, such as: walking, wheelchair, cars, buses, taxis, bicycles etc.? This includes entering/exiting transportation, such as cars, buses and taxis.	
*3. **TRANSFERRING** – How much human assistance does the person need on a consistent basis for safe transfer, including from bed/chair to wheelchair, walker or standing position; onto and off of toilet; and into and out of bath or shower?	
*4. **EATING** – How well is the person able to eat and drink safely? This includes ability to cut, chew and swallow foods. (Note – if person is tube fed or fed intravenously, circle "0" if s/he can feed self independently, or "1", "2", or "3" if s/he requires another person to assist.) Excludes meal preparation	
*5. **MEAL PREPARATION** – How well is the person able to safely obtain and prepare routine meals? This includes the ability to independently open containers and use kitchen appliances. (Note – if person is tube fed or fed intravenously, circle "0" if s/he can prepare the tube/IV feeding independently, or "1", "2", or "3" if s/he requires another person to assist.)	
Comments:	

* Denotes required fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

II. FUNCTIONAL SCREEN - *continued*

A. ADLs & IADLs (cont'd)

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used

ADL SCALE	
0 =	**Independent** - Person is independent in completing activity safely
1 =	**Supervision** - Person can complete activity safely with cueing, set-up or standby assistance OR limited/occasional physical/hands-on assistance
2 =	**Physical Assistance** - Person can participate in activity but requires physical/hands-on assistance to complete safely
3 =	**Total Dependence** - Person is completely dependent on others to complete activity safely

Activity	Score
***6. TOILETING** – How well is the person able to use the toilet, commode, bedpan or urinal safely? This includes flushing, cleansing of self, changing of protective garment, adjusting clothing, washing hands, managing an ostomy or catheter. Excludes transfer and continence (Note – limited hands-on assistance includes emptying bedpans.)	
***7. BATHING –** How well is the person able to bathe, shower or take sponge baths safely for the purpose of maintaining adequate hygiene and skin integrity? Includes washing hair. Excludes transfer (Note – limited hands-on assistance includes helping with hard to reach areas, such as the back.)	
***8. DRESSING** – How well is the person able to safely dress and undress as necessary regardless of clothing type? This includes ability to put on prostheses, braces, anti-embolism hose and choice of appropriate clothes for the weather and for personal comfort. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit. (Note: if person can dress independently, but normally requires 30 minutes or longer doing so, score as "Supervisory" (1).)	
***9. PERSONAL HYGIENE** – How well is the person able to perform personal hygiene/grooming activities safely, including but not limited to combing hair, shaving, oral care? Exclude nail care and washing hair (which is addressed under bathing).	
***10. MEDICATION MANAGEMENT** – How well is the person able to safely manage and administer pills, liquids, inhalers, nebulizers, eye drops, ear drops, self-administered injectables, IV medications, medication pumps? Excludes insulin and monthly injections, such as B-12 shots.	
Does person use insulin? If yes, go to Question 11. Otherwise, skip to Question 12	
Comments:	

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

II. FUNCTIONAL SCREEN – *continued*

A. ADLs & IADLs (cont'd)

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used

***11. INSULIN ADMINISTRATION** How well is the person able to safely manage and administer insulin? If person does not use insulin, select N/A for all items.

Activity	Yes	No	N/A
DOES PERSON USE INSULIN? (Please check Yes, No, or N/A) (If Yes, answer Questions 11a, 11b, and 11c. Otherwise, skip to Question 12.)			
*11a. Can person administer finger sticks and understand Accu-Chek® (glucose testing) results?			
*11b. If on a fixed dose, can person self-inject insulin with a pre-filled syringe?			
*11c. If on a sliding scale, can person draw up the correct amount and inject insulin?			

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

II. FUNCTIONAL SCREEN - *continued*

A. ADLs & IADLs (cont'd)

- Enter score in box (must be whole number)
- Consider the past 30 days
- Score based on functionality achieved with assistive device(s), if used (Includes catheter and ostomy)

CONTINENCE SCALE	
0 = Complete voluntary control	
1 = Incontinent episodes less than weekly	
2 = Incontinent episodes once per week	
3 = Incontinent episodes two or more times per week	
Activity	**Score**
*12. **BLADDER CONTINENCE** – How well is the person able to voluntarily control the discharge of body waste from the bladder?	
*13. **BOWEL CONTINENCE** –How well is the person able to voluntarily control the discharge of body waste from the bowel?	

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

II. FUNCTIONAL SCREEN - *continued*

A. ADLs & IADLs (cont'd)

14. UNDERLYING CAUSES OF ADL/IADL LIMITATIONS – Check all that apply

Part A General Underlying Causes (across ADLs/IADLs)				Part B Specific to Medication Management	
Physical Impairments:		***Physical Impairments (cont'd):***		***Physical Impairments:***	
	Amputation		Paralysis		Cannot Crush Pills
	Balance Problems		Physiological Defect		Cannot Open Blister Pack
	Bladder Incontinence		Poor Dentition		Cannot Open Containers
	Bowel Incontinence		Sensory Impairment – Hearing		Cannot use Ear/Eye Drops
	Catheter		Sensory Impairment – Vision		Liquid Medications Only
	Choking		Shortness of Breath		Poor Coordination
	Decreased Endurance		Swallowing Problems		Unable to Draw Medication
	Fine or Gross Motor Impairment		Tube Feeding		Unable to put Medication in Mouth
	Fracture(s)		Weakness		Unable to Read Labels
	Lack of Assistive Devices	***Supervision Need/Mental Health:***		***Supervision Need:***	
	Limited Range of Motion		Behavior Issues		Complex Regimen
	Muscle Tone		Cognitive Impairment		Does not Follow Frequency
	Neurological Impairment		History of Falls		Does not Follow Dosage
	Obesity		Lack of Motivation/Apathy		Forgets to Take Medication
	Ostomy		Memory Impairment		Mixes Alcohol with Prescription Drugs
	Oxygen Use	***Other (specify)***		***Other (specify)***	
	Pain				

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

II. FUNCTIONAL SCREEN - *continued*

A. ADLs & IADLs (cont'd)

15. ASSISTIVE DEVICES – Check all devices that the person either uses today or needs. (Note that some devices with multiple ADL/IADL uses are listed only under the most common ADL/IADL application. Check box even if used or needed for a different ADL/IADL.)

Uses Today	Needs	Device
Mobility Related:		
		Cane – Standard
		Cane – Quad
		Cane Grip Strap
		Crutches
		Leg Brace
		Motorized Scooter
		Prostheses
		Ramp
		Walker – Not Wheeled
		Walker – Wheeled
		Walker with Seat (trough)
		Wheelchair – Standard
		Wheelchair – Motorized
		Wheelchair – Customized
Transfer Related:		
		Bed Pull-Up Straps
		Furniture Risers
		Grab Bars/Hand Rails
		Hospital Bed
		Leg Lifters
		Lift Chair
		Lift/Ceiling Track System
		Mechanical Lift (not chair)
		Overhead Trapeze
		Raised Seat Cushion
		Shower Slide/Swivel Chair
		Transfer Board/Disk
Eating/Meal Preparation Related:		
		Adaptive Cups/Plates
		Adaptive Utensils
		Home Delivered Meals
		Mechanically Altered Food

Uses Today	Needs	Device
Toileting/Continence Related:		
		Adult Diapers
		Bedside Commode/Bedpan
		In/Out Catheter
		Raised Commode Seat
		Toilet Paper Wiper Aid
		Washable Bed Pads
		Zipper Hooks/Pulls
Bathing Related:		
		Handheld Shower Head
		Shower Chair
		Shower Slide/Swivel Chair
		Specialized Brushes
Dressing Related:		
		Button Hook
		Dressing Stick
		Elastic Shoe Laces
		Long-Handled Shoe Horn
		Sock Aid
Personal Hygiene Related:		
		Hair Dryer Stand
		Velcro Handles/Cushion Holders for Brushes, Razors, Toothbrushes
Medication Related:		
		Alarm Device
		Pillbox
Communication Related:		
		Communication Board
		Other Communication Aid (specify)
Other (Specify):		

Comments:

*Denotes required fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

II. FUNCTIONAL SCREEN - *continued*

B. COMMUNICATION/SENSORY – Enter score in box (must be whole number)

	Score

*1.	**EXPRESSIVE COMMUNICATION** - How well is the person able to express him or herself in their own language, including non-English languages and ~~ASL~~ American Sign Language (ASL) or other generally recognized non-verbal communication?
0.	Person can fully communicate with no impairment or only mild impairment (e.g., slow speech)
1.	Person can fully communicate with the use of assistive device
2.	Person can communicate only basic needs to others
3.	Person has no effective communication
Comments:	

	Score

*2.	**ABILITY TO UNDERSTAND OTHERS** – How well is the person able to understand verbal information content?
0.	Person understands
1.	Person usually understands – may miss some part/intent of message
2.	Person sometimes understands – responds adequately to simple, direct communication
3.	Person rarely/never understands
Comments:	

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

II. FUNCTIONAL SCREEN - *continued*

B. COMMUNICATION/SENSORY (cont'd) – Enter score in box (must be whole number)

Score

*3.	**VISION** – The ability to see in adequate light, and with glasses (if used)
0.	ADEQUATE – Sees fine detail, including regular print in newspapers/books
1.	MILDLY IMPAIRED – Sees large print, but not regular print in newspapers/books
2.	MODERATELY IMPAIRED – Limited vision; not able to see newspaper headlines, but can identify objects
3.	HIGHLY IMPAIRED – Object identification in question, but eyes appear to follow objects
4.	SEVERELY IMPAIRED – No vision OR sees only light, colors and shapes; eyes do not appear to follow objects
UNK	Unable to determine appropriate score

Comments:

Score

*4.	**HEARING** – The ability to hear with hearing appliances (if used)
0.	HEARS ADEQUATELY – Normal talk, TV, phone
1.	MILDLY IMPAIRED – Minimal difficulty when not in quiet setting
2.	MODERATELY IMPAIRED – Hears in special situations only; speaker has to adjust tonal quality and speak distinctly
3.	HIGHLY IMPAIRED – Absence of useful hearing
UNK	Unable to determine appropriate score

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

III. COGNITIVE SCREEN (ORIENTATION)

What is the person's level of awareness to person, place and time?

- Check appropriate boxes, based on responses (check "does not know" if person is non-responsive due to severe cognitive impairment, such as advanced Alzheimer's)
- A caregiver should be familiar with the person's orientation on a daily basis. It can be a relative or non-relative, including a staff member in an Assisted Living Facility or Nursing Home
- Instruct caregivers to consider the past 90 days

☐ Check if Caregiver not present (skip Caregiver Judgment items in III.A.1 through III.A.4)

1. PERSON

*At time of screen, does person know their:				Caregiver Judgment (if present)		
First Name	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Last Name	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Caregiver's Name	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:						

2. PLACE

*At time of screen, does person know their:				Caregiver Judgment (if present)		
Immediate Environment	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Place of Residence	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
City	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
State	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:						

***Denotes Required Fields**

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

III. COGNITIVE SCREEN (ORIENTATION) - *continued*

3. TIME

*At time of screen, does person know their:				Caregiver Judgment (if present)		
Day	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Month	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Year	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Time of Day	☐ Knows	☐ Does not know	☐ Unable to determine	☐ Always knows	☐ Usually Knows	☐ Seldom/ never knows
Comments:						

*	← *Screener's Score*	*Caregiver's Score* →	

***4. OVERALL RATING OF ORIENTATION/SITUATIONAL AWARENESS**

0 = No problem – Person is completely unimpaired or has slight impairment or confusion of doubtful clinical significance (e.g., misses the date by one day).

1 = Mildly or Moderately Disoriented/Confused – Mild, but definite impairment or confusion (e.g., unsure about orientation to time, or some impairment in a few aspects of short term or long term memory) OR moderate impairment or confusion (e.g., unsure about where s/he is and what is occurring right now, or cannot recall important events in his/her life)

2 = Severely Disoriented/Confused – Thoroughly disoriented or confused to person, place, time and what is occurring right now; significant impairment in short term and/or long term memory OR unable to respond due to severe cognitive impairment.

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

IV. MOOD/PSYCHOSOCIAL & BEHAVIORS

A. CURRENT MOOD/PSYCHOSOCIAL – Check current Mood/PsychoSocial status as applicable (exception – check "Psychological Illness History" if illness was diagnosed but is no longer symptomatic)

Mood/PsychoSocial			
PsychoSocial Problems	**Check if Applicable**	***Significant Losses***	**Check if Applicable**
Psychological Illness Present		Death of Spouse	
Psychological Illness History		Death of Other Family Member or Friend	
Depression		Death of Pet	
Nervousness/Anxiety		Other (Specify in Comments)	
Crying		***Significant Changes***	
Insomnia		Change in Residence	
Nightmares		Divorce/Separation	
Loss of Appetite		Retirement	
Concerns Regarding Potential PsychoSocial Situation		Other (Specify in Comments)	
Poor Eye Contact		***Threats/Victimization***	
Withdrawal from Activities of Interest		Financial Concerns	
Loneliness/Isolation		Safety Concerns	
Other (Specify in Comments)		Victim of Assault/Theft	
		Victim of Abuse/Neglect	
		Other (Specify in Comments)	
Comments:			

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

IV. MOOD/PSYCHOSOCIAL & BEHAVIORS - *continued*

B. BEHAVIORS

- Consider behaviors during the past 90 days that required some level of intervention to address (You may mark "H" for behaviors that occurred historically, defined as greater than 90 days ago but within the past two years)
- For interventions, consider the most common level of intervention required
- "Easily altered" applies to persons who can be redirected verbally without difficulty
- "Not easily altered" applies to persons who can be redirected verbally with difficulty, or who require physical or chemical restraints (to the extent allowed by law)

Frequency of Behavior:	***If "Frequency of Behavior" is Greater than "0" What Intensity of Intervention is Required?***
0 = Has not occurred	0 = Behavior is easily altered
H = Has occurred historically (greater than past 90 days)	1 = Behavior is not easily altered
1 = Occasional behavior requiring intervention no more than once per week	
2 = Frequent behavior requiring intervention more than weekly, but less than daily	
3 = Constant behavior requiring daily intervention	

***1. VERBALLY AGGRESSIVE:** Threatening, screaming and/or cursing at others

*BEHAVIOR FREQUENCY *(circle)*	*REQUIRED INTERVENTION INTENSITY *(circle)*
0 H 1 2 3	0 1

*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" *(check all that apply)*

❑ Falsely accuses others of stealing ❑ Spitting at others ❑ Verbal threats ❑ Screaming/cursing at others

❑ Other *(please specify)*: _____

***2. PHYSICALLY AGGRESSIVE:** Hitting, shoving, scratching and/or sexually abusing others

*BEHAVIOR FREQUENCY *(circle)*	*REQUIRED INTERVENTION INTENSITY *(circle)*
0 H 1 2 3	0 1

*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" *(check all that apply)*

❑ Combative regarding personal care ❑ Hits/shoves/scratches others ❑ Intimidating/threatening physical harm

❑ Sexually abusive ❑ Throws items at others

❑ Other *(please specify)*: _____

***3. RESISTIVE:** Inappropriately stubborn and uncooperative. Includes both passive and active behaviors.

*BEHAVIOR FREQUENCY *(circle)*	*REQUIRED INTERVENTION INTENSITY *(circle)*
0 H 1 2 3	0 1

*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" *(check all that apply)*

❑ Refuses to eat ❑ Refuses to participate in personal care (non-violent) ❑ Refuses to take necessary medications

❑ Other *(please specify)*: _____

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

IV. MOOD/PSYCHOSOCIAL & BEHAVIORS - *continued*

B. BEHAVIORS (cont'd)

***4. WANDERING/ELOPEMENT:** Movement with no rational purpose, seemingly oblivious to needs or safety

*BEHAVIOR FREQUENCY *(circle)*	*REQUIRED INTERVENTION INTENSITY *(circle)*
0 H 1 2 3	0 1

*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" *(check all that apply)*

❑ Leaves home and becomes lost ❑ Wanders – seeking exit ❑ Wanders – NOT seeking exit

❑ Other *(please specify)*: _____

***5. INAPPROPRIATE/UNSAFE:** Includes socially inappropriate behaviors, unsafe behaviors and disruptive behaviors. Excludes aggression toward others.

*BEHAVIOR FREQUENCY *(circle)*	*REQUIRED INTERVENTION INTENSITY *(circle)*
0 H 1 2 3	0 1

*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" *(check all that apply)*

❑ Breaks objects ❑ Hiding items ❑ Hoarding ❑ Inappropriate noises

❑ Inappropriate talk or actions ❑ Inappropriate toileting/menses ❑ Puts inappropriate non-food items in mouth

❑ Repetitive movements ❑ Rummaging/takes belongings ❑ Unsafe cooking ❑ Unsafe smoking

❑ Other *(please specify)*: _____

***6. SELF-INJURIOUS:** Repeated behaviors that cause harm to self. Also can include suicidal behavior.

*BEHAVIOR FREQUENCY *(circle)*	*REQUIRED INTERVENTION INTENSITY *(circle)*
0 H 1 2 3	0 1

*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" *(check all that apply)*

❑ Biting/scratching/picking at self ❑ Head slapping/banging ❑ Suicidal

❑ Other *(please specify)*: _____

***7. OTHER:** Delusions, hallucinations, manic symptoms, mood swings

*BEHAVIOR FREQUENCY *(circle)*	*REQUIRED INTERVENTION INTENSITY *(circle)*
0 H 1 2 3	0 1

*BEHAVIOR EXAMPLES – IF FREQUENCY IS GREATER THAN "0" *(check all that apply)*

❑ Delusions ❑ Hallucinations ❑ Manic symptoms/mood swings

❑ Other *(please specify)*: _____

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

V. MEDICAL SCREEN

A. MEDICAL CONDITIONS

- Check only those diagnoses that have a current relationship to ADL status, cognitive/behavioral status, medical treatments, skilled nursing care or risk of death

1. Cardiovascular:		***5. Musculoskeletal:***		***7. Ophthalmologic/EENT:***	
	Angina (chest pain)		Arthritis/Osteoarthritis		Blind
	~~Arteriosclerotic~~ Arteriosclerotic Heart Disease		Arthritis/Rheumatoid		Cataracts
	Cardiac Dysrhythmias		Degenerative Joint Disease		Diabetic Retinopathy
	Congestive Heart Failure		Fracture/Unspecified		Glaucoma
	Cerebral Vascular Accident		Fracture/Hip		Hearing Impaired/Deaf
	Deep Vein Thrombosis		Fracture/Pathological		Macular Degeneration
	Hypertension		Gout	***8. Psychiatric/Mood:***	
	Hypotension		Joint Repair or Replacement		Anxiety Disorder
	Myocardial Infarction		Missing Limb		Bipolar Disorder
	Peripheral Vascular Disease		Osteoporosis		Depression (major)
	Transient Ischemic Attack	***6. Neurological:***			Depression (other)
2. Endocrine:			ALS (Lou Gehrig's Disease)		Schizophrenia/other psychoses
	Diabetes IDDM (insulin dependent)		Alzheimer's	***9. Respiratory:***	
	Diabetes NIDDM (non-insulin dep.)		Aphasia		Asthma
	Hyperlipidemia		Autism		Bronchitis/Chronic
	Hyperthyroidism		Cerebral Palsy		Chronic Obstructive Pulmonary
	Hypothyroidism		Dementia (not Alzheimer's)		Disease
	Obesity		Developmental Disability		Emphysema
3. Gastrointestinal:			Hemiplegia		Influenza
	GI Ulcers		Huntington's Disease		Pneumonia
	Gastroesophageal Reflux Disease		Impairment/Central Nervous		Tuberculosis (positive Mantoux)
	Ulcerative Colitis		Mental Retardation	***10. Other:***	
4. Genitourinary:			Multiple Sclerosis		Allergies (specify type in comments)
	Renal Failure		Muscular Dystrophy		Anemia
	Urinary Retention		Neuropathy		Cancer
	Urinary Tract Infection		Paraplegia		Cellulitus
			Parkinson's Disease		Coma
			Quadriplegia		Constipation
			Seizure Disorder		Decubitus Ulcer (describe number
			Traumatic Brain Injury		and type(s) in comments)
					Explicit Terminal Diagnosis
					Functioning at Brain Stem Level
					HIV/AIDS
					Septicemia
					Other (specify in comments)
Comments: ***Use Medical Summary at end of Medical Section, if needed.***					

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

V. MEDICAL SCREEN – *continued*

***B. HEALTH-RELATED SERVICES** - Indicate frequency if receives today and amount is known

Health-Related Services Needed or Receiving (Indicate which)	Currently Receives	Needs	Service Frequency					
			1 to 3 Times/ Month	Weekly	2 to 5 Times/ Week	1 to 2 Times/ Day	3 to 4 Times/ Day	Over 4 Times/ Day
Bladder/Bowel:								
▪ Bowel Dilation								
▪ Catheter Care								
▪ Ostomy Care								
Feedings:								
▪ Parenteral Feedings/TPN								
▪ Special Diet (specify)								
▪ Tube Feedings								
Injections/IV:								
▪ Intramuscular/Subcutaneous Injections								
▪ Intravenous Infusion Therapy								
Medications:								
▪ Drug Administration								
▪ Drug Regulation								
Rehabilitative Nursing:								
▪ Bowel/Bladder Training								
▪ Range of Motion								
▪ Teaching/Training								
▪ Turning and Positioning								
▪ Other Rehab Nursing								
Respiratory:								
▪ Chest-Physio Therapy								
▪ CPAP								
▪ Oxygen								
▪ Small Volume Nebulizer								
▪ Suctioning								
▪ Trach Care								
▪ Ventilator								
Skin Care:								
▪ Non Bowel/Bladder Care								
▪ Pressure/Other Ulcers								
▪ Wound Care								
Therapies:								
▪ Alcohol/Drug Treatment								
▪ Individual/Group Therapy – Psycho/Social								
▪ Occupational Therapy								
▪ Physical Therapy								
▪ Respiratory Therapy								
▪ Speech Therapy								
▪ Vocational Rehabilitation								
Other Services & Treatments:								
▪ Chemotherapy/Radiation								
▪ Fluid Intake/Output								
▪ Hemodialysis								
▪ Peritoneal Dialysis								
▪ Restraints								
▪ Other *(specify)*:								

Comments: *Use Medical Summary at end of Medical Section, if needed.*

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

V. MEDICAL SCREEN – *continued*

B. CURRENT MEDICATIONS

- Include both prescribed and over-the-counter medications currently being taken
- Identify dosage, frequency and prescribing physician (as applicable) for all current medications
- Check Psychotropic box if a medication is being administered for the purpose of treating a behavioral health condition

Medications	Dosage	Frequency	Prescriber	Psychotropic
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

V. MEDICAL SCREEN – *continued*

D. *MEDICAL STABILITY & STATUS - For stability, record episodes in past 90 days.

Incident Type		Number in past 90 days	
*1.	Emergency Room Visits		
*2.	Hospitalizations (if any, provide details, including discharge dates and diagnoses in Comments below)		
*3.	Physician Office Visits (total across all doctors)		
*4.	Number of Falls		
Medical Status		**Yes**	**No**
*5.	Does person have an active, life threatening condition? (If yes, describe in Comments below)		
*6.	Is person medically stable? (If no, describe in Comments below)		
*7.	Does person require 24-hour/7-day per week care? (If yes, describe in Comments below)		
*8.	Does person have a severe orthopedic and/or neurological impairment, and possess ~~rehabilitative potential?~~ maximum medical improvement potential?		

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

V. MEDICAL SCREEN – *continued*

***E. MEDICAL SUMMARY (Attachments Acceptable)**

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

VI. SOCIAL SUPPORTS

☐ **N/A – Person resides in nursing facility or other institutional setting and IS NOT SEEKING PLACEMENT IN THE COMMUNITY (if checked, skip section)**

1. Primary Caregiver

☐ Check if person has primary caregiver/contact, but person is not present at screening
☐ Check if person has no caregiver or emergency contact

*Name (*First, Middle Initial, *Last)

*Relation
☐ Spouse ☐ Child ☐ Parent ☐ Other Relative _____ ☐ Friend ☐ Other _____

Lives with Person?
☐ Yes ☐ No

Designated Representative? (If answered "No" to both, enter address below)
☐ Yes ☐ No

*Street Address: (Write "Same" if lives with person and/or "DR" if Designated Representative)

*City, *State: | *Zip Code: | *Telephone:

Frequency of Support		***Type(s) of Support Typically Provided***	
	Individual is emergency contact only/not serving as caregiver (skip remainder of table)		Personal Care/ADLs (e.g., bathing, dressing etc.)
	Every day		Housekeeping/chores
	Several days per week		Meal Preparation
	At least once per week		Medication administration & oversight
	Less than once per week		Shopping/Errands
*	← Estimated hours of support provided in previous seven days		Supervision for safety
			Transportation
			Other (specify in comments)

*Caregiver's health (self-reported)
☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

*Caregiver's emotional well-being (self-reported)
☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

*Is caregiver able/willing to maintain current level of support in foreseeable future? If no, explain in comments
☐ Yes ☐ No

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

VI. SOCIAL SUPPORTS – *continued*

2. *Formal Agency Supports* ❑ Check if person has no formal agency supports and complete "Needs" portion of table only

Agency 1 Name			Agency 2 Name		
Address (Street, City, Zip Code)			Address (Street, City, Zip Code)		
Telephone:			Telephone:		
Receives	***Needs***	***Long Term Care Services***	***Receives***	***Needs***	***Long Term Care Services***
		Adult Day Care			In-Home Respite
		Assisted Living			In-Home Nursing Respite
		Attendant Care			Institutional Respite
		Attendant Call System			Intermittent Skilled Nursing
		Case Management			Medication Administration/Oversight
		Chore Services			Personal Care
		Environmental Modifications			Programming
		Home Health Aide			Transition Services
		~~Expanded Home Health~~ Home Health, Expanded			Transportation (Escorted and non-Escorted)
		Homemaker			Other (specify in comments)
		Home Delivered Meals			

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

VII. HOME ENVIRONMENT

- ❑ **N/A – Person resides in nursing facility or other institutional setting and IS NOT SEEKING PLACEMENT IN THE COMMUNITY (if checked, skip section)**
- ❑ **Person resides in nursing facility or other institutional setting and is seeking placement in the community (check desired dwelling type and provide further details about availability of desired community placement in comments section, including whether placement arrangements have been made.)**

Characteristics	For identified problems, address necessary action(s) in comments.		
***Dwelling Type**	**Check One**	***Heating/Cooling/Safety**	**Check if Present**
House		Air Conditioning Type: _____	
Apartment		Heat Type: _____	
Trailer		Working Smoke Detectors	
Congregate Housing		Fire Extinguishers	
Other (specify in comments)		Clear Pathways	
***Structural Concerns**	**Check if Applicable**	911 System	
Accessibility		Emergency Response System	
Roof		Severe Weather Procedure	
Walls		***Neighborhood**	**Check One**
Floor		High Crime	
Other (specify in comments)		Moderate Crime	
***Sanitation Concerns**	**Check if Applicable**	Low Crime	
Pests			
Plumbing			
Sewage			
Comments:			

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

VIII. INFORMED CHOICE

The purpose of this section is to match the person's care needs, strengths and desires with DOM-covered long term care programs, to ensure the person, and person's family, is able to make an informed choice from the available DOM-covered options.

☐ **N/A – Person resides in nursing facility or other institutional setting and IS NOT SEEKING PLACEMENT IN THE COMMUNITY (if checked, skip section)**

1. Person Strengths

Document person's strengths as they relate to remaining in their home or another community setting. Check all that apply and provide additional detail in comments section, as appropriate.

	Social Supports		*Outside Activities/Networks*		*Resources*
	Supportive Family		Active in church/faith-based organizations		Adequate housing
	Supportive Friends		Active in clubs/recreational groups		Financially secure
	Supportive Neighbors		Active in sports		Adequate transportation
	Other (specify in comments)		Employed		Safe environment
			Volunteers		Other (specify in comments)
			Other (specify in comments)		

	Health & Wellness		*Personal Outlook*
	Adequate physical health		Positive self-image
	Balanced mental health		Positive view of others
	Adequate self-care ability (with support)		Positive view of the future
	Adequate access to medical care		Desire to remain in (return to) home/community
	Adequate communication skills		Sense of purpose
	Commitment to health		Ability to ask for and accept help
	Knowledge about how choices impact health		Other (specify in comments)
	Other (specify in comments)		

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

VIII. INFORMED CHOICE - *continued*

*2. *Program Options & Desired Assistance*	Desired Assistance (**CHECK ALL THAT APPLY** within potential placement options)				
	Nursing Facility	**Assisted Living**	**Elderly/ Disabled Waiver**	**Independent Living Waiver**	**TBI/SCI Waiver**
Nursing Facility (all inclusive)					
Adult Day Care					
Assisted Living Placement					
Attendant Care					
Attendant Call System					
Case Management					
Chore Services					
Environmental Modifications					
Escorted Transportation					
Homemaker					
~~Expanded Home Health*~~ Home Health, Expanded*					
Home Delivered Meals					
In-Home Respite					
In-Home Nursing Respite					
Institutional Respite					
Medication Admin/Oversight					
Personal Care					
Programming					
~~Intermittent Skilled Nursing~~ Skilled Nursing, Intermittent					
Specialized Equipment/Supplies					
Transition Services					
Transportation					

** ~~Expanded Home Health~~ Home Health, Expanded can include: Home Health Aide, Skilled Nurse, Physical Therapy and Speech Therapy*

Comments:

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

VIII. INFORMED CHOICE – *continued*

Person's Name: _____
Date: _____

Note – If completing PAS electronically, record options presented below. Obtain signatures and initials on hard copy PAS or hard copy "PAS-Informed Choice" form. Retain hard copy document with signatures and initials for later DOM review (if requested)

3. Person Choice

Option	Presented as Option, based on Screen?		Person's Choice (initial)
	Yes	No	
Nursing Facility Placement			
Assisted Living Waiver			
Elderly/Disabled Waiver			
Independent Living Waiver			
TBI/SCI Waiver			
Other (specify):			
~~Comment:~~ Comments:			

**Screener:*

I have informed the person and/or the person's legal representative of the available DOM-covered long term care options, including alternatives to Nursing Facility placement, based on the results of the PAS and the person's desired services.

*Signature	*Date	*Printed Name	*Credentials

**Person:* Name: _____

I hereby acknowledge my participation in this screening process, agree that I have had long term care program options explained to me and have indicated my choice by initialing in the appropriate box above. I also have been informed that the Medicaid program has financial eligibility requirements not addressed as part of this screen. I authorize the agency or attending physician to provide the DOM with information necessary to meet the federal requirements for review and/or assist me in seeking long term care services.

**Signed:* _____ Person/Legal Representative _____ Date

**Signed:* _____ Witness _____ Date

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

IX. LEVEL II DETERMINATION

THIS SECTION IS TO BE COMPLETED ON ALL PERSONS BEING CONSIDERED FOR PLACEMENT IN A NURSING FACILITY

- Complete Part A to determine if person is exempt from Level II evaluation due to medical diagnosis or other qualifying factor. Yes answers must be supported by data entered in previous PAS sections, as indicated.
- Complete Part B to document if person has a mental illness or is mentally retarded/developmentally disabled (Part B must be completed if one of the exemption criteria are marked in Part A)
- Referrals must be made even if physician certifies that, in his/her opinion, a Level II evaluation is not indicated at this time (physician finding will be considered by DOM when making final determination regarding the person's need for an evaluation)

A. Exemption Criteria

Criteria	As Documented in:	Yes	No
1. Person has diagnosis of Alzheimer's Disease or other Dementia	Section V.A		
2. Person is in need of nursing care for a terminal illness with a life expectancy of six (6) months or less	Section V.A		
3. Person has severe physical illness such as coma, functioning at brain stem level or diagnosis such as severe COPD, Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis and Severe Congestive Heart Failure	Section V.A and ICD-9 portion of physician certification form		
4. Person is ventilator dependent	Section V.B		
5. Person needs respite care for 10 days or less			
6. Person needs short term convalescent care (likely to be less than 30 days) and is being admitted directly from a hospital			
7. Person needs provisional admission pending further assessment in an emergency situation requiring protective services with placement in a nursing facility not to exceed 7 days			

If any question in Part A has been answered "Yes", person is exempt from Level II evaluation. (Part B must still be completed)

*Denotes Required Fields

IX. LEVEL II DETERMINATION - *continued*

B. Level II Referral

Criteria	As Documented in:	Yes	No
1. Person has diagnosis of Mental Retardation	Section V.A		
2. Person has a history of, or presents any evidence of cognitive or behavior functions that indicate the need for an MR evaluation	Section V.C		
3. Person has a diagnosis of a major mental illness	Section V.A and ICD-9 portion of physician certification form		
4. Person has a recent history of a mental illness	Section IV.B.7 (score of 1, 2, 3 or H)		
5. Person takes, or has a history of taking, psychotropic medication(s)	Section V.C		

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

X. PAS SUMMARY & PHYSICIAN CERTIFICATION (Hard Copy PAS)

Hard copy PAS summary and certification instructions: ***Transfer information from earlier PAS sections to summary, as directed below.*** *Obtain ICD-9 diagnosis data/certification from physician and forward to DOM/LTC along with PAS Informed Choice – Person Choice page or separate Informed Choice form.*

PAS Score (to be completed by DOM/LTC only) →

*Name (Last, First, Middle):		
Medicaid Number:	Medicare Number:	
*SSN:	*DOB (~~MM/DD/YR~~) (~~MM/DD/CCYY~~)	*Gender (check box) ☐ Male ☐ Female

II.A - ADL/IADL Level of Need for Assistance in past 30 days – Circle the appropriate numbers

*ADL/IADL	Inde-pendent	Super-vision	Physical Assist	Total Depen.	ADL/IADL	Inde-pendent	Super-vision	Physical Assist	Total Depen.
1. Mobility/Ambulation	0	1	2	3	6. Toileting	0	1	2	3
2. Community Mobility	0	1	2	3	7. Bathing	0	1	2	3
3. Transferring	0	1	2	3	8. Dressing	0	1	2	3
4. Eating	0	1	2	3	9. Personal Hygiene	0	1	2	3
5. Meal Preparation	0	1	2	3	10. Medication Management	0	1	2	3

***II.A Question 11 - Insulin Dependence** – Circle Yes, No or N/A (if not insulin-dependent)

Needs assistance w/finger sticks and/or understanding glucose testing results	Yes	No	N/A	Needs assistance drawing-up and/or injecting insulin	Yes	No	N/A

***II.A - Bladder/Bowel Continence – Frequency of Incontinence in past 30 days** - Circle the appropriate numbers

Incontinence Type	None	<1 per Week	Once per Week	2+ Times per Week	Incontinence Type	None	<1 per Week	Once per Week	2+ Times per Week
*12. Bladder Incontinence	0	1	2	3	*13. Bowel Incontinence	0	1	2	3

***II.A Question 14 - Number of ADL Underlying Causes Recorded (Part A only)** - Circle the appropriate number

0	1	2	3	4	5	6	7	8	9	10 or more

***II.B Question 3 - Vision – Level of Impairment** – Circle the appropriate number

	None	Mild	Moderate	High	Severe	UNK/Unable
Vision	0	1	2	3	4	UNK

***III - Level of Orientation to Person, Place & Time (11 question test)** - Circle the appropriate numbers

*Incorrect answers (out of 11)	0	1	2	3	4	5	*Screener Judgment of Impairment Level	None	Mild/ Moderate	Severe
Mark here if unable to determine ☐	6	7	8	9	10	11		0	1	2

***IV.B - Behavior – Frequency in past 90 days requiring intervention** – Circle the appropriate numbers (Mark "H" as 0)

*Behavior Frequency	None	Less than Weekly	Less than Daily	Daily		*Intensity of Intervention	Easily Altered	Not Easily Altered
1. Verbally Aggressive	0	1	2	3	*If > 0* →	1. Verbally Aggressive	0	1
2. Physically Aggressive	0	1	2	3	*If > 0* →	2. Physically Aggressive	0	1
3. Resistive	0	1	2	3	*If > 0* →	3. Resistive	0	1
4. Wandering/Elopement	0	1	2	3	*If > 0* →	4. Wandering/Elopement	0	1
5. Inappropriate/Unsafe	0	1	2	3	*If > 0* →	5. Inappropriate/Unsafe	0	1
6. Self-Injurious	0	1	2	3	*If > 0* →	6. Self-Injurious	0	1

*Denotes Required Fields

MISSISSIPPI DIVISION OF MEDICAID
Pre-Admission Screening (PAS) Application for Long Term Care

X. PAS SUMMARY & PHYSICIAN CERTIFICATION (Hard Copy PAS) - *continued*

*Name (Last, First, Middle):	*PAS Date:

***V.A & V.D.8 - Selected Active Medical Conditions – Circle Yes or No**

Alzheimer's or non-Alzheimer's Dementia	Yes	No	Traumatic Brain Injury	Yes	No
Paralysis – Hemiplegia	Yes	No	Severe orthopedic or neurological impairment (as indicated by a "yes" in V.D.8 – Medical Status)	Yes	No
Paralysis – Paraplegia or Quadriplegia	Yes	No			

***V.B - Selected Health-Related Services – Indicate if person currently receives or needs (Circle Yes if either)**

Catheter Care	Yes	No	Physical Therapy	Yes	No
Occupational Therapy	Yes	No	Pressure/Other Ulcer Care	Yes	No
Ostomy Care	Yes	No	Tube Feeding	Yes	No
Oxygen	Yes	No	Turning and Positioning	Yes	No

IX - Federal Pre-Admission Screen & Resident Review (PASRR) – For Nursing Facility Admissions – Circle Yes or No

Part A – Level II Evaluation Exemption Criteria	Yes	No	Part B – Level II Referral Criteria	Yes	No
Person has diagnosis of Alzheimer's/Dementia?	Yes	No	Person has a diagnosis of Mental Retardation?	Yes	No
Person is in need of nursing care for terminal illness?	Yes	No	Person has a history of, or presents any evidence of cognitive or behavior functions that indicate the need for an MR evaluation?	Yes	No
Person has severe physical illness?	Yes	No	Person has a diagnosis of a major mental illness?	Yes	No
Person is ventilator dependent?	Yes	No	Person takes, or has a history of taking, psychotropic medications?	Yes	No
Person needs respite care for 10 days or less?	Yes	No			
Person needs short term convalescent care (likely to be less than 30 days) and is being admitted directly from hospital?	Yes	No			
Person needs provisional admission pending further assessment in an emergency situation requiring protective services with placement not to exceed 7 days?	Yes	No			

***Person's Long Term Care Program Choice – Mark One** (based on program selected in PAS Section VIII or on Informed Choice Form)

Nursing Facility →		E&D Waiver →		Assisted Living Waiver →	
Independent Living Waiver →		TBI/SCI Waiver →		Other: _____ →	

Screener:

*Signature _____ *Date _____ *Printed Name _____

This section to be completed by Physician

*Primary Diagnosis Description	ICD-9 Code	Secondary Diagnosis Description	ICD-9 Code
	.		.

Physician Certification:

This person is appropriate for Medicaid long term care services. In the event of Nursing Facility placement, a Level II evaluation ☐ **IS INDICATED** ☐ **IS NOT INDICATED** at this time (check one).

*Signature _____ *Date _____ *Printed Name _____ *License Number _____

*Denotes Required Fields